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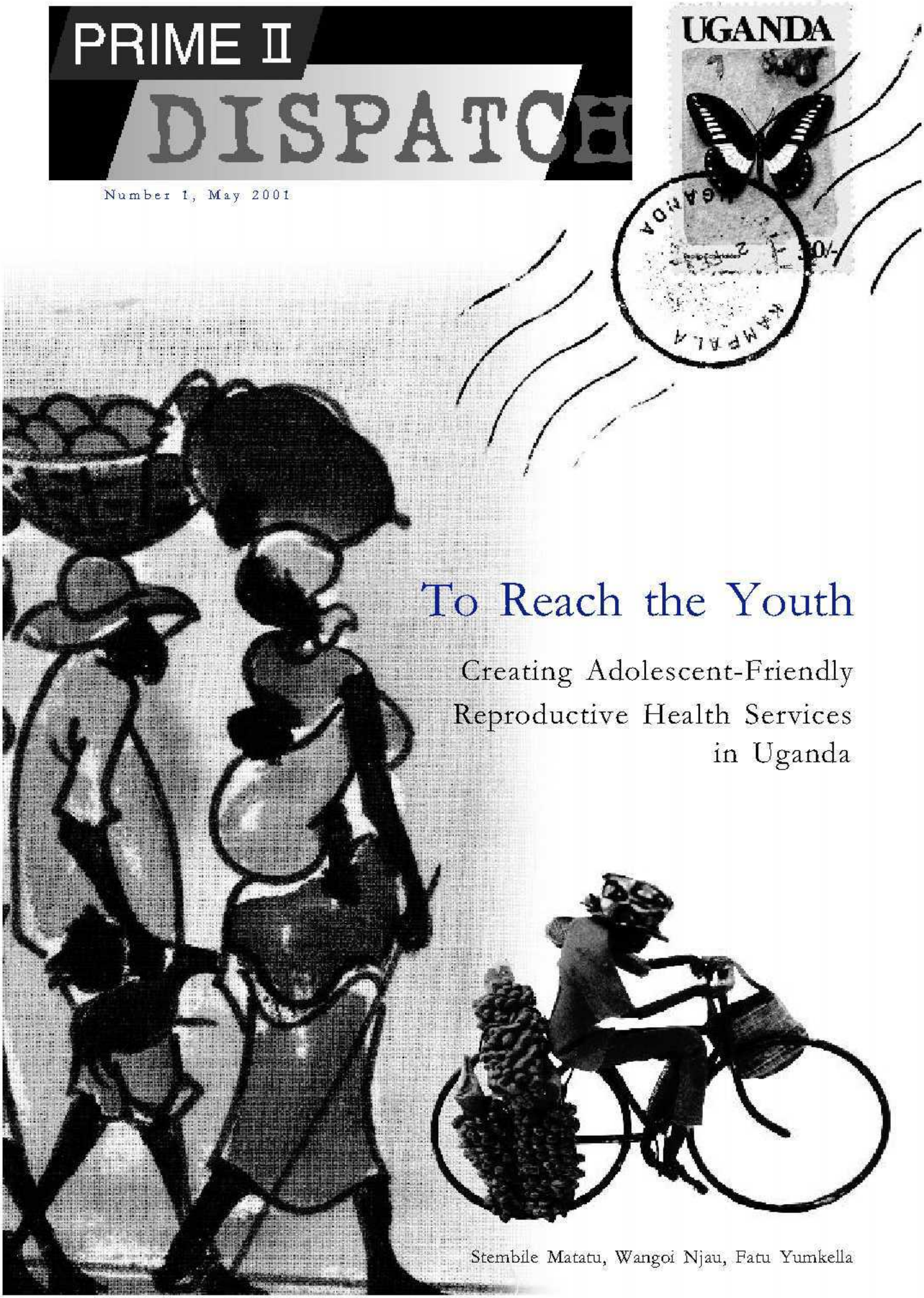

To Reach the Youth

Creating Adolescent-Friendly Reproductive Health Services in Uganda

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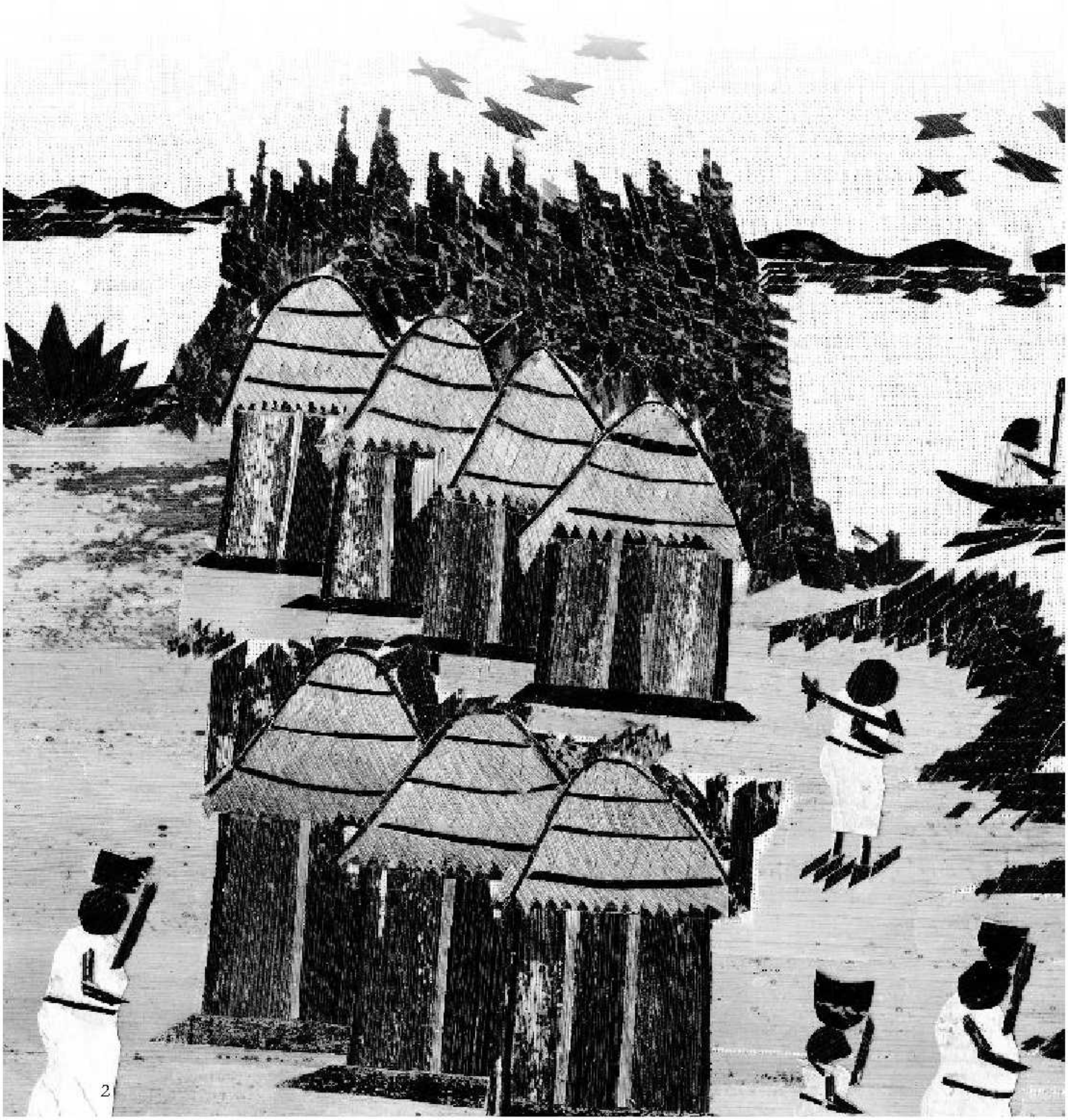


The Situation in Uganda

While the transition from childhood to adolescence presents challenges for parents and communities worldwide, the situation in the Republic of Uganda is striking. One quarter of the population between the ages of 15 and 19 have their first sexual experience by the age of 15, and nearly half of all Ugandan women become mothers by the age of 18. Adolescents account for 30% of the pregnancy-related deaths in Uganda, about 30% of which are caused by postabortion complications.[1] Adolescents in Uganda also report a high incidence of negative health consequences as a result of unprotected sexual activity.

The Adolescent Reproductive Health (ARH) initiative was conceived by the Uganda Ministry of Health (MOH), the PRIME Project, and the Delivery of Improved Services for Health (DISH) project after it became apparent that Ugandan adolescents were not making use of public health care facilities even though they suffered from myriad health problems. As an initial stage of intervention, the MOH and the District Health Management Team (DHMT) in the district of Jinja in southeastern Uganda, in collaboration with PRIME and DISH, established an ARH pilot project within four existing health care centers in Jinja. The sites chosen were Buwenge, situated in a densely populated rural community along the Jinja-Kamuli road; Bugembe, on the outskirts of Jinja Town on the main highway connecting Uganda and Kenya; Kakira, a government facility within the expansive Kakira sugar plantation; and Walukuba, located within Jinja municipality in a crowded area along the shores of Lake Victoria. The project was launched in September 1998 and completed in August 2000.

Socioeconomic factors aggravate the problem of providing adolescent reproductive health services in Jinja, where the economy depends on small-scale agriculture. Poverty and unemployment are endemic, education levels are low, basic transportation is unreliable and expensive, and shelter is often inadequate and overcrowded. Community leaders and parents widely hold that mechanisms for managing adolescent sexuality—indeed, adolescent behavior in general—within traditional value systems have broken down. They cite a variety of reasons, including urbanization, internal and external military conflicts, and changing roles for individuals within families and communities. Adolescent girls become involved in sexual activities with married "sugar daddies," adolescent *boda boda* (bicycle operators) and taxi drivers, and other economically attractive men in exchange for small items their parents cannot afford to buy for them. Adolescent boys have the same kinds of relationships with older married women. Poverty and the exchange of sex for material things—along with drug and alcohol

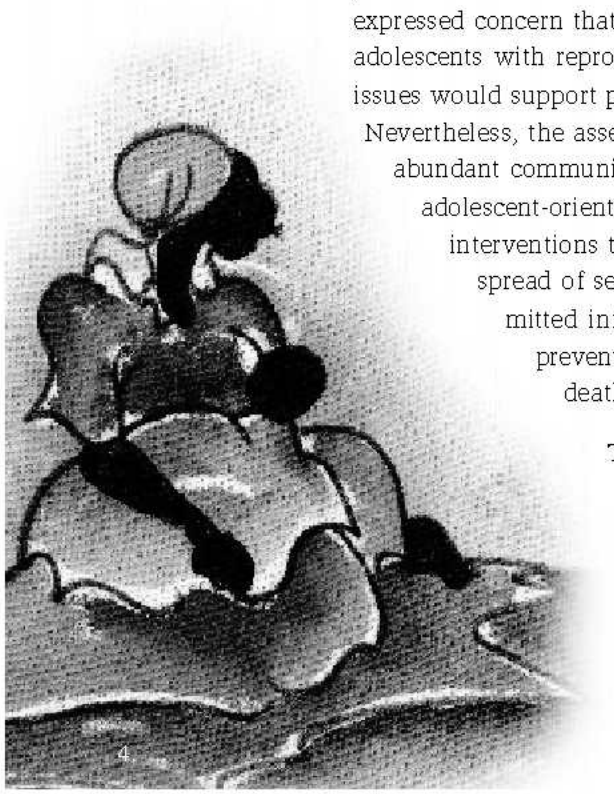
"I am 13 years old and would like to know the meaning of love and why is it that the boys like to play sex any time?"

abuse—underlie many of the adolescent sexual activities in Jinja, including early marriage, prostitution, extramarital affairs, and rape—which is reported to occur frequently and after which the victims suffer social stigmatization.

Further complicating adolescent health issues in Jinja, adolescent reproductive health problems occur in the context of other prevalent diseases, including malaria, tuberculosis, anemia, whooping cough, dysentery, sickle-cell anemia, scabies, ringworm, and cholera. But reproductive and sexual problems—especially sexually transmitted infections—are paramount among the health-related concerns of the adolescents themselves.

The PRIME Baseline Study

In order to identify and assess the ARH training and service needs of the four health care centers in Jinja, PRIME implemented a baseline study in 1998.[2] PRIME researchers conducted in-depth interviews and focus group discussions with adolescents, parents, health workers, and community leaders, and made facility observations and record checks. The study revealed divided opinions about what constituted appropriate provision of adolescent sexual and reproductive health information and services. Both providers and community members expressed concern that helping adolescents with reproductive health issues would support promiscuity. Nevertheless, the assessment found abundant community interest in adolescent-oriented health care interventions to stem the spread of sexually transmitted infections and prevent adolescent deaths.



The study showed gaps in the skills and knowledge of providers of ARH services at the centers, and concluded that at district health centers the vast majority of adolescent clients sought only antenatal or maternal health services. Adolescents interviewed as part of the study reported a number of reasons for not seeking other reproductive health and family planning services:

- Little knowledge of available reproductive health services
- A perception of negative provider attitudes toward adolescent sexuality
- Inconvenient health care center schedules
- Lack of anonymity and confidentiality in health care center environments
- Fear of ostracism by peers
- Embarrassment about disclosing sexually transmitted infections and fear of screening for HIV/AIDS
- Misinformation and myths surrounding the use of family planning methods
- Inability to afford the providers' charges—both official and unofficial—for services, tests, medications, and family planning methods.

The findings of the baseline study, disseminated at a meeting in Jinja with community leaders and representatives of parents and adolescents,

"I am 16 years old. I have a girlfriend that loves me and I also love her too. But whenever I like to be with her she doesn't want me to use a condom. What can I do?"

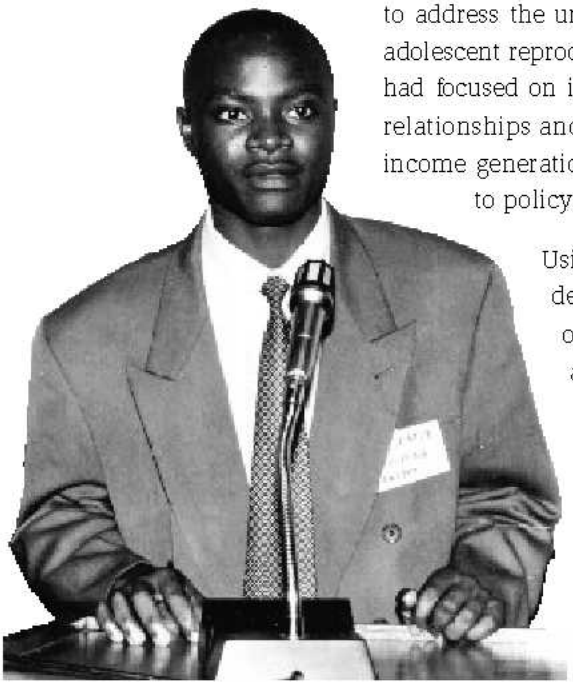
pointed to four primary objectives for the ARH pilot project:

- Attract adolescents into existing health care facilities
- Integrate ARH services into those facilities
- Encourage and monitor behavior changes in ARH service providers
- Track the use of ARH services by adolescents.

The ARH Pilot Project

The ARH pilot project in Jinja created the first service delivery programs in Uganda to attract adolescents by considering their distinct needs as articulated by the adolescents themselves. Previous programs attempting to address the unmet demand for adolescent reproductive health services had focused on information, education, relationships and negotiation skills, income generation, and responses to policy needs.

Using a curriculum developed by a team of clinical trainers and a social scientist specializing in adolescents, PRIME trained three DISH project staff and three district trainers, two of whom were also service providers.



At a presentation in Kampala about the results of the ARH pilot project, Jinja adolescent George Musenze spoke of his days hanging out under the mango tree smoking with his buddies and talking about sex. He then told how the activities at the health care facility had brought about positive changes in his lifestyle as well as enlightening him about family planning and reproductive health.

These six trainers then trained four service providers from each pilot site in two-week residential workshops comprised of a week of classroom instruction and a week of guided clinic experience. The providers in turn imparted knowledge informally to other providers at their respective facilities. In addition to educating the providers about specific issues in adolescent reproductive and sexual health, the training emphasized changes in behaviors, non-judgmental service delivery, improved counseling and communications skills, and other information necessary to provide adolescents with comprehensive reproductive health services. Although adolescents were not directly involved in the training program, their views and preferences, as expressed during the baseline interviews, guided its design.

To reduce barriers further, the pilot health care centers extended their hours of operation into the afternoon so adolescents could visit after school. Recreational activities—including soccer, netball, and cards—were offered to attract adolescents to the health centers. The providers then showed

"I am a boy of 18 years. What is the effect of using condoms more than one time?"

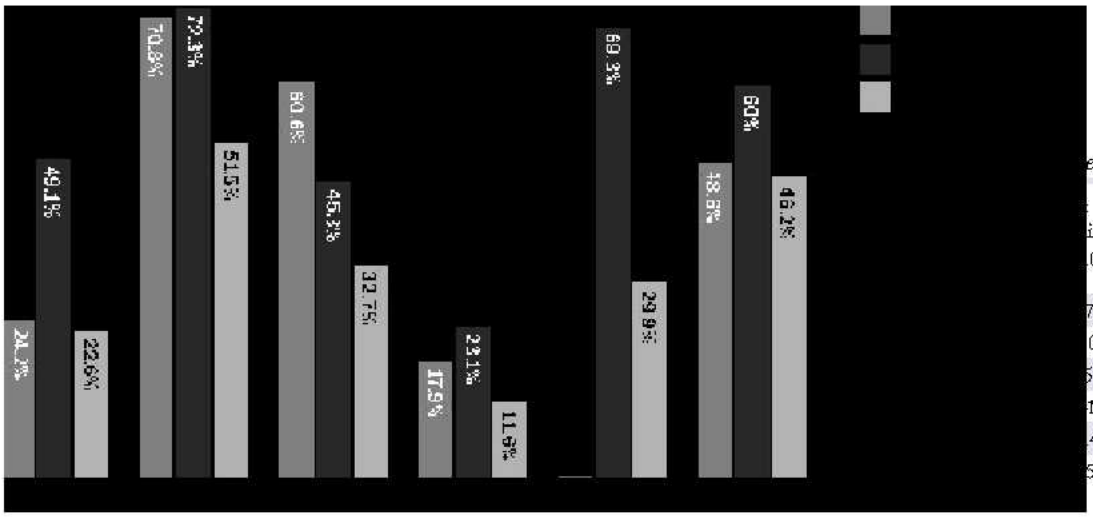
videos on ARH issues to stimulate discussion and debate and set the stage for group and individual counseling, targeted role play and question-and-answer sessions. Consultation rooms—previously viewed as the province of the seriously ill—became places for adolescents to visit with providers for treatment, counseling, or just to chat.

The project endeavored to ensure the quality of service delivery through intense and sustained monitoring of the providers by an experienced team of supervisors. As part of this process, PRIME gathered and disseminated data about service usage, providing regular feedback to the providers and thus enhancing their performance and enthusiasm for the project. Through regular debriefings and written reports, project leaders also kept health-unit management committees and the District Director of Health Services informed about project goals and results as a means of generating broad support for the provision of ARH services.

Methods and Results

In an evaluation conducted in August 2000 to determine the effectiveness of the ARH program, the four pilot health care facilities in Jinja district were contrasted with four sites with similar geographic, demographic, and service characteristics that had not received the ARH intervention.[3] The evaluation used several methods of data collection to gather relevant information, including focus group discussions, in-depth interviews, knowledge assessments, exit interviews, facility observations and service statistics comparisons.[4]

Figure 1: Proportion of adolescents among clients seeking services at pilot sites (pre-intervention) and at pilot and comparison sites (post-intervention)



erived

ine (00)	Pilot at follow-up (n/N x 100)
785	5419/11038
07	937/1296
57	312/689
16	1065/4604
4	547/789
54	856/1427

Information gathered from client registers

Jinja

Water lies at the heart of Jinja district, which boasts the source of the River Nile, a southern border on Lake Victoria, the spectacular Bujagali Falls, and Owen Falls Dam, which generates Uganda's electricity. While the country's industrial base has shifted from Jinja to Uganda's capital of Kampala—80 kilometers to the southwest—the district still has a larger urban population than most of Uganda's 39 districts (the municipality of Jinja is the country's second largest city after Kampala). Unemployment is high and subsistence farming remains the primary source of income in Jinja, where the climate is hot and rainy and 70% of the land is arable. Popular crops include beans, cassava, finger millet, maize, bananas, sweet potatoes, soybeans, peas, coffee, cotton, and sugarcane. Fishing is also an important source of sustenance and revenue. The Basoga—part of the Bantu ethnic group—form the largest component of Jinja's population, estimated at 345,000, and Lusoga is the primary language besides English.[5]

Before and After Comparison of Quantitative Service Data

Figure 1 compares the proportion of adolescents before and after the intervention who sought services at the pilot sites. The six categories of services analyzed are outpatient (OPD), antenatal (ANC), maternity, laboratory, family planning (FP), and sexually transmitted infections (STI). The pre-intervention percentages represent data accumulated for the four months prior to the baseline data collection visit; the post-intervention figures cover the four months before the August 2000 evaluation. Due to the small sample sizes, statistical comparisons are not possible for these data.

The figure shows that more than twice as many adolescents sought outpatient services following the intervention than during the pre-intervention phase, and the number of adolescents receiving laboratory services and STI management increased significantly after the intervention. Qualitative data from the providers also indicates that adolescents at the pilot sites post-intervention were more likely to seek help for an STI at an earlier, manageable stage. Before the intervention—and at the comparison sites—they mainly sought help after they had tried all other alternatives, by which time the infection had progressed considerably.

Unfortunately, the ages of family planning clients had not been collected on client registers at the pilot sites before the intervention began, so could not form part of the baseline data. As a result, a before and after assessment of the proportion of adolescents seeking family planning services at the pilot sites is unavailable. However, it is important to note that adolescents represented more than two thirds of the family planning clients served at the sites post-intervention.

Qualitative data from interviews with adolescents suggest that after the intervention some female adolescents chose abstinence as a way of taking charge of their sexuality. Many of them reported that before the intervention they were having sex to please their boyfriends and only using a family planning method when their boyfriends asked them to do so. This change in behavior, combined with

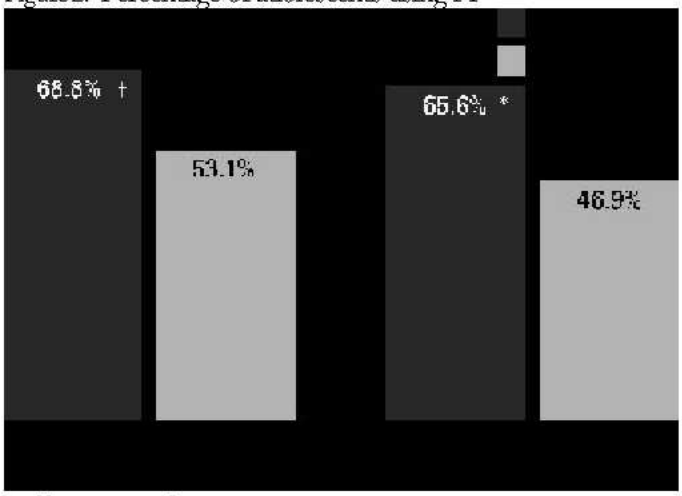
	Comparison at follow-up (n/N x 100)
1038	788/3495
	430/835
589	159/487
	189/1627
'89	87/291
	152/329

"If you kiss a girl who is having AIDS and yet your lips have no wounds, can you also get the disease?"

the high proportion of adolescent family planning clients, may have served to decrease unplanned pregnancies—an impression reinforced by the post-intervention decrease in the proportion of adolescent clients seeking maternity services at the pilot sites.

Figure 1 also compares the proportion of adolescents seeking services in the six categories at pilot and comparison sites during the four "follow-up" months before the August 2000 evaluation. Here again, statistical tests on the differences could not be performed due to the small sample sizes. However, as the figure demonstrates, a greater proportion of adolescents sought outpatient care at the pilot sites in all of the service categories, especially for family planning and management of sexually transmitted infections. Evaluators also found that requests for counseling and testing for HIV rose sharply at pilot sites after each question-and-answer session on STI/HIV/AIDS. The much larger proportion of adolescents seeking services for STI management at pilot sites points to a critical need for STI services throughout Uganda.

Figure 2: Percentage of adolescents using FP



† *Difference is significant at p < .10* * *Difference is significant at p < .05*

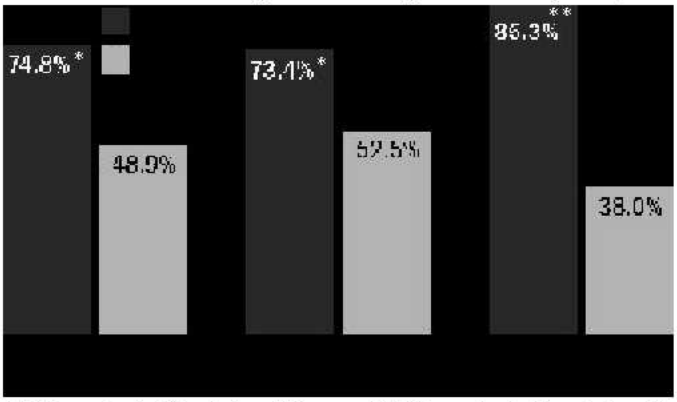
Reported Use of Family Planning by Adolescents

Adolescents served by the pilot sites were more likely to report that they had ever used a family planning method than those visiting the comparison sites, as shown in Figure 2. More importantly, adolescents served at pilot sites were significantly more likely to report that they were currently using a method. As stated above, qualitative data also suggest that some adolescents had chosen abstinence due to their increased awareness of the risks of sexual activity. In any case, the 20% higher number of family planning method users among pilot site adolescents is promising.

Adolescent Knowledge of Reproductive Health

Higher levels of family planning method use and STI/HIV/AIDS awareness are evident among adolescents served at the pilot sites. These figures underscore the importance of the knowledge imparted at the facilities through question-and-answer sessions, counseling, videos, and other activities. Derived from a random sampling of adolescents visiting pilot and comparison sites, Figure 3 shows that pilot site adolescents tested significantly higher in their knowledge of family planning methods, adolescent health problems, and factors that predispose adolescents to health problems than contemporaries at comparison sites in an equivalent sample. (Predisposing factors were defined for the purposes of the study as lack of communication between parents and children, lack of communication between

Figure 3: Mean percentage scores on ARH knowledge tests for adolescents at pilot and comparison sites (N=64)



* *Difference is significant at p < .05* ** *Difference is significant at p < .01*

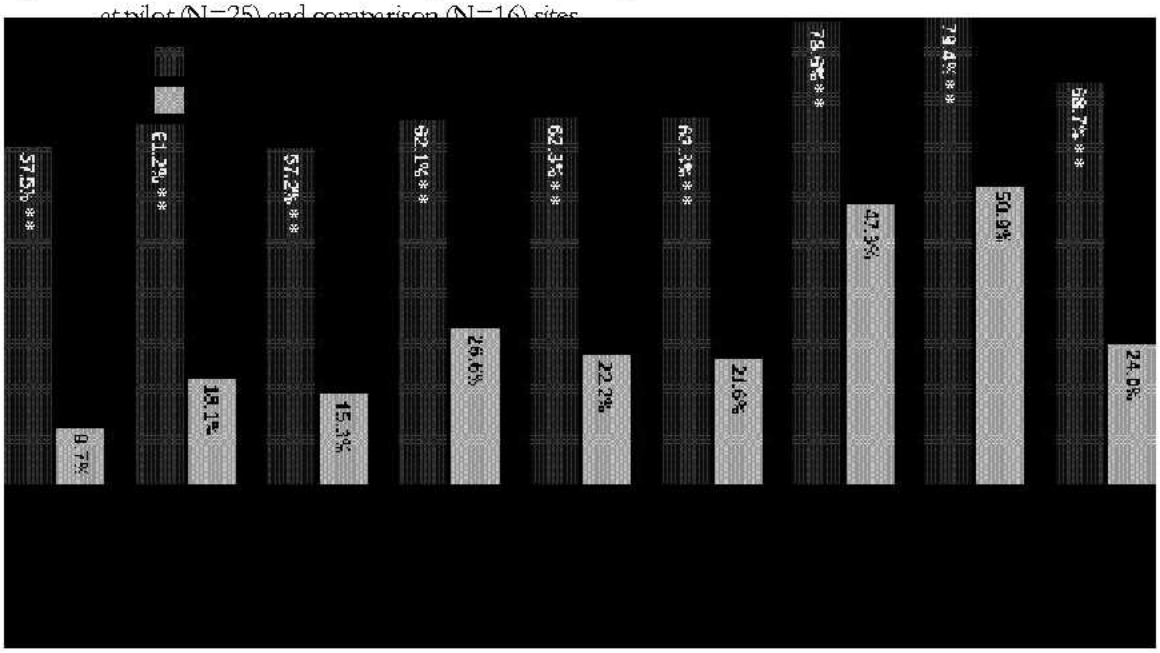
adolescents and health care workers, harmful traditional practices, and lack of income-generating activities.) The substantial difference in test scores on knowledge about the use and importance of family planning methods is especially encouraging: an 85% mean score for adolescents at the pilot sites, compared with a 38% mean result among comparison site adolescents.

Provider Knowledge of Adolescent Health

Not surprisingly, the higher levels of reproductive health knowledge among adolescents at the pilot sites in Jinja mirrored higher levels of knowledge among the service providers at those sites. As confirmed in Figure 4, health workers at pilot sites scored substantially higher than their comparison site counterparts in eight critical categories of ARH service and management.

In interviews with adolescents, health care workers, health management committees, and local residents, project evaluators found continued support for the provision of ARH services and related activities in the communities around the pilot sites. ARH-trained health workers displayed a marked change in their attitudes toward adolescents, with the majority of those interviewed indicating that they regarded adolescent clients positively and non-judgmentally and were willing to assist them at any time. In turn, the adolescents interviewed from the pilot group conveyed favorable impressions of the health workers. Finally, while some parents had expressed reservations and even opposition at baseline to providing family planning and reproductive health services and information to adolescents, qualitative data suggest that community and parental support of the providers played an important role in the success of the program.

Figure 4: Mean scores on ARH knowledge tests for service providers at pilot (N=25) and comparison (N=16) sites



Conclusions and Challenges

The trends reflected in the evaluation data show that the ARH pilot program in Jinja district succeeded on many levels. The program achieved its goals of fostering better relationships between adolescents and health care providers, enticing more adolescents to take advantage of reproductive health services and improving the ARH knowledge levels of the health care workers. Consequently, adolescents visiting or seeking care at the pilot facilities showed markedly higher levels of awareness of ARH issues and knowledge about family planning methods and the prevention of sexually transmitted infections. The program generated positive feedback about the ARH intervention from all of the important stakeholders at the pilot sites—adolescents, health care workers, community leaders and residents, the District Health Management Team in Jinja, and the Uganda Ministry of Health.

Upgrading the knowledge and skill levels of the pilot site providers remains a challenge, however. Although the pilot group scored dramatically higher than the comparison group on ARH knowledge tests, their percentages of correct answers remained lower than optimal, indicating the need for additional training and instruction. Among the challenges expressed by the providers themselves—including such basic problems as power outages and supply shortages—is the need to sustain adolescents' interest in the health care facilities through varying the recreational activities and educational materials available at the sites. During the pilot project, implementers continually searched for new videos on adolescent reproductive health issues in an effort to keep visitors from becoming bored by hearing and seeing the same messages repeated in much the same ways.

While the pilot program succeeded in its strategy of drawing adolescents to the health centers through sports and games, the question has been raised as to whether or not the centers are an appropriate location for such activities. This issue is compounded by the popularity of adolescent-oriented recreation with pre-adolescents who might not yet be mature enough for some of the reproductive health topics being presented at the centers in conjunction with the

Jinja adolescent Sarah Tageya and her mother, Florence Akalya, are advocates for the ARH pilot project. As a "disco kid" with little knowledge about sexuality, Sarah was at risk for becoming pregnant or contracting HIV/AIDS. Now she has the self-respect to say "no" to boys and is also aware that she can have her partner use a condom if she wants to have sex. Florence feels that the project helped girls like Sarah to develop more self-esteem and notes that unplanned pregnancies have declined in local schools.

"I am 15 years. Is it true that getting an STI is a sign of growing up and becoming a man?"

other activities. Separating children by age and developing appropriate health messages for the pre-adolescents then becomes a challenge for providers. Some adolescents expressed a desire for their own separate health care facilities for another reason—so that they would face less risk of bumping into parents or non-supportive adults when seeking reproductive health services.

Changing attitudes about the provision of ARH services will likely be a difficult hurdle for similar interventions elsewhere in Uganda, as it was a painful struggle for some of the Jinja providers to reach a balance between their personal and cultural beliefs and their professional obligations. The broader challenge for the ARH project in Jinja district—and for plans to expand the program in Uganda and replicate this model in other countries—will be the ability to maintain and monitor each facility's progress in ARH care beyond the implementation period. Consistent technical assistance and supervision from PRIME and DISH, including regular visits to the pilot sites, proved crucial to the success of the program in Jinja. The cost implications involved in replicating and sustaining such assistance, especially over extended periods, will hold ramifications for the long-term success of each ARH intervention.

Notes

1 *Statistics Department (Uganda) and Macro International. Uganda demographic and health survey, 1995. Calverton, MD: Statistics Department (Uganda) and Macro International; 1996.*

2 *Njau W, Matatu S, Rogo K. Report of a baseline assessment for adolescent reproductive health initiative in Jinja district of Uganda: the final report. Intrah, PRIME Project; 1999 (unpublished).*

3 *Unfortunately, no data was collected at baseline for the comparison sites. Therefore, it is not possible to assess comparability and relative increases in relation to the pilot sites.*

4 *A forthcoming technical report will detail the methodology and tools used in greater detail. See also: Njau W. PRIME Trip Report No. P-2-61. Intrah, PRIME Project; 2000.*

5 *Sources: www.government.go.ug; The Uganda Housing and Population Census, 1991; The Statistical Abstract 1997, Bureau of Statistics, Entebbe, Uganda; Jinja District Health Office Three-Year Health Plan, 1993.*

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